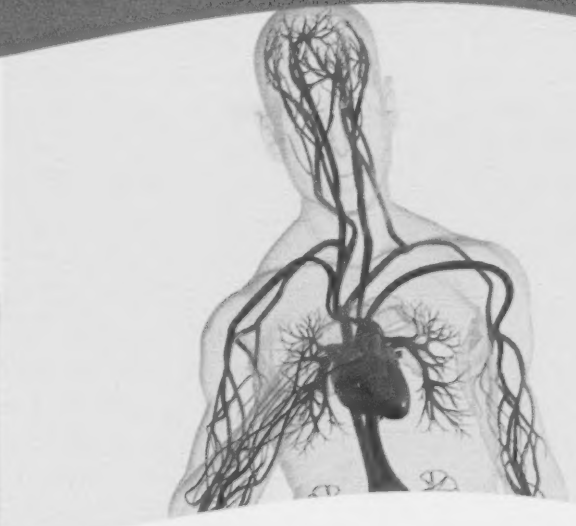
Central East **LHIN**

Community First Integrated Health Service Plan 2013-2016

November 2012



Ontario
Local Health Integration Network

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Executive Summary

The momentum of change for health care in Ontario has never been greater. The Central East LHIN and the 2013-16 Integrated Health Service Plan (IHSP) will drive the evolution of the local health care system to promote better health, better care, and better value for our residents.

In fact, Ontario's LHINs have been a significant driver of health care improvements in Ontario since 2006. It is recognized that real change can be a slow process. The gains we are achieving now, and hope to gain in the future, are in part a result of the seeds LHINs sowed in their first two Integrated Health Service Plans.

The Central East LHIN 2013-16 Integrated Health Service Plan sets out a bold, but realistic, road map for health care improvement for our region. In order to realize our vision of "Engaged Communities-Healthy Communities" and fulfill our LHIN's mission and mandate, the 2013-16 IHSP lays out four new innovative strategic aims and common enablers that will serve as the aspiration of our health care community for the next three years.

These strategic aims and enablers take their cue from the Ministry of Health and Long-Term Care's *Action Plan for Health* and the common objectives of Ontario's 14 LHINs. Most of all, they are rooted in our LHIN's commitment to lead the creation of an integrated local health care system that delivers on the "Triple Aim" of better health for our community, better patient experience, and better value-for-money from our health care system.

The overarching theme of this IHSP is Community First. We know the sustainability of our health care system requires us to rethink how we keep people healthy and well in the community to prevent avoidable hospitalization and the need for long-term care. Its now time we put our energy and resources behind our words.

A Community First approach requires focused and disciplined actions to create an integrated community-based health system that is able to pro-actively respond to emerging health care trends in our communities. With dramatic changes ahead to health care finance, clinical practice, demographic shifts, and technology – these changes are too large and too important to leave to chance. The rollout of the "Home First" philosophy taught us we need to be less implicit and more explicit in the coordination of patient care across health care sectors. We need a plan. That is why we have focussed the 2013-16 IHSP on "Community First."

The 2013-16 IHSP strategic aims are rooted in this Community First approach:

- *Reduce the demand for long-term care so that seniors spend 320,000 more days at home in their communities by 2016.*
- *Continue to improve the vascular health of residents so they spend 25,000 more days at home in their communities by 2016.*
- *Strengthen the system of supports for people with Mental Health and Addiction issues so they spend 15,000 more days at home in their communities by 2016.*
- *Increase the number of palliative patients who die at home by choice and spend 12,000 more days in their communities by 2016.*

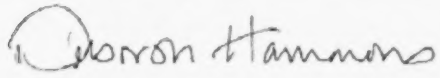
Achieving these aims requires a concerted effort of the LHIN, our health service providers, other health and social service partners and, of course, local residents and their caregivers.

This IHSP identifies a set of common enablers related to health system design and improvement that consistently weave between all of our strategic aims. Those common enablers are:

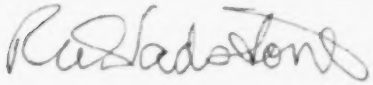
- Improving Access to Primary Care
- Access and Wait Times – Including Emergency Department, Surgical and Diagnostic Services
- Health System Funding Reform
- System Design & Integration
- Transitions in Care & Electronic Health Information Management
- Quality & Safety

Over the course of this 2013-2016 Integrated Health Service Plan, the Central East LHIN will continue to monitor and report on its progress to both the Ministry of Health and Long-Term Care and the general public. Local residents will have access to up-to-date knowledge on the performance of their local health system regarding access, quality and efficiency. Residents, patients and providers will know how well we are doing in the achievement of our strategic aims.

Given the economic challenges facing the province of Ontario, and the growing needs of our aging communities, now is the time to be bold in our ambitions and clear in our aims. This Integrated Health Service Plan sets a course for outcomes that will have a direct impact on patients, clients, consumers, residents, caregivers, and health care workers. Together, we will achieve these strategic aims while realizing foundational change in the way health care is experienced and delivered.



Deborah Hammons
Chief Executive Officer
Central East LHIN



Wayne Gladstone
Chair of the Board
Central East LHIN

Introduction

The 2013-2016 Central East Local Health Integration Network's (LHIN) Integrated Health Service Plan is a local road map to better health, better care and better value for the residents and health service providers in the Central East region. The strategies, projects and improvements presented in the Integrated Health Service Plan (IHSP, or Plan) are rooted in the common vision and priorities of the Ontario Ministry of Health and Long-Term Care and the Central East LHIN, as well as in evidenced-based and leading-edge practice in the planning and delivery of health services.

Most importantly, the IHSP is informed by those people who directly deliver and receive health services each day in the Central East LHIN. Patients, clients, consumers, residents, caregivers, allied health, administrators, nurses, physicians and community leaders played a significant role in the creation of the IHSP, and will play an even bigger role in the achievement of the IHSP's objectives.

The IHSP is a three-year strategic plan for the Central East health care system. Like all of the province's 14 LHINs, the Central East LHIN has developed the IHSP to guide the activities and accountabilities of local health service providers. The Plan provides an overview of the current health care system, identifies areas for focused improvement, and sets standards for achievement. All of this is done to advance the Central East LHIN vision of "Engaged Communities. Healthy Communities".

The general public and other stakeholders want to better understand what value integration and the Central East LHIN brings to the health care system, as well as what the Central East LHIN aims to achieve "by when" and "by how much." The single most important element of this IHSP is the identification of four system-level strategic aims for the Central East LHIN that are in keeping with provincial and local priorities:

- *Reduce the demand for long-term care so that seniors spend 320,000 more days at home in their communities by 2016.*
- *Continue to improve the vascular health of residents so they spend 25,000 more days at home in their communities by 2016.*
- *Strengthen the system of supports for people with Mental Health and Addiction issues so they spend 15,000 more days at home in their communities by 2016.*
- *Increase the number of palliative patients who die at home by choice and spend 12,000 more days in their communities by 2016.*

These four strategic aims converge into a single broader system theme of Community First. By "thinking" and "acting" Community First, we intend to help Central East LHIN residents spend more time in their homes and their communities, and fewer days in hospitals and long-term care homes. By emphasizing community-based health care services we will enhance the quality and sustainability of the Central East LHIN health care system, as well as improve the patient experience.

We continue to recognize certain client groups as priority populations within our strategic aims. In addition to seniors, persons with mental illness and/or addictions, and people with chronic disease, the Central East LHIN also recognizes the francophone community and our Aboriginal partners as priority populations. The Central East LHIN is a very diverse region. Thus, we also recognize that there are other disparities or inequities in health care access and outcomes for many communities in the Central East LHIN.

We will continue to measure and close the gap using the best available evidence, applying our efforts and available resources in partnership with others. Our vision, mission and strategic aims will be achieved for all people and communities within the Central East.

How to Read This IHSP

This IHSP begins by showing how the Central East LHIN strategy is aligned with province-wide priorities. In the first section we discuss provincial priorities as outlined by the Ministry of Health and Long-Term Care, as well system imperatives that are shared by the 14 LHINs. Next we describe the process by which the strategic aims were established. The Central East LHIN's vision and mission are the foundation of all the work we do. The LHINs overarching strategic directions, which are our ultimate goals, guided the creation of these strategic aims. In the third section we provide data to describe the Central East LHIN. Demographic information and health-statistics helped us determine the most important areas of focus.

In the fourth section we describe our strategic aims. The meaning of our overarching aim, Community First, is outlined in detail. We discuss why the health care system needs to focus on community-based care, and how we will take steps to reorient the health care system. Our four strategic aims are each focused on one of four priority populations: seniors, those with vascular disease or who are at risk for developing vascular disease, individuals with mental health and addiction issues, and people requiring palliative care. The strategic aims are defined in detail in the following sections with each section describing the rationale for focusing on each priority population, the accomplishments that we will build on over the next three years, the rationale for the strategic aims themselves, and a description of how we will accomplish and measure improvements.

In the final section we identify common themes, or system enablers, that are important components of all our strategic aims. Improving Access to Primary Care, Access and Wait Times , Health System Funding Reform, System Design & Integration, Transitions in Care & Electronic Health Information Management, Quality & Safety are all important drivers of change. In this section we describe how these common themes will help us improve system sustainability, population health and patient experience.

Provincial Action Plan for Health Care 2012 & Ontario LHIN Imperatives

This chapter summarizes the current priorities of the government and the provincial LHINs' health imperatives to illustrate how they set the context for the 2013-2016 IHSP.

Provincial Context

Supporting the delivery of health care in a challenging environment and with a mandate for transformation Ontario's LHINs are responsible for the allocation of about half of the province's health care expenditures, or about $22 billion in funding as of 2011 (Estimates, 2011/12). Working with the Ministry of Health and Long-Term Care, LHINs ensure that local and regional plans align with provincial priorities for the health care system to improve access to care and ensure sustainability.

Between 2003-04 and 2011-12, health sector funding in the provincial budget increased at an average rate of 6.1% annually, for a total increase of $17.9 billion (Ontario Budget, 2012). However, the province now faces substantial fiscal pressures. In an effort to reduce expenditure growth to ensure sustainability and manage those challenges, the government has stated that "funding for the health care system cannot continue to grow at past rates," (Ontario Budget, 2012). This will require getting better value for money from all parts of the health care system to maintain access to services and continue to improve the quality of care.

A key driver of future health care costs, in addition to general inflation and changes in technology, is the fact that the population of Ontario is getting older and as people age they require more health care. Specifically, in ten years there will be 43% more seniors in the province than there are now and in twenty years there will be twice as many (Ontario Budget, 2012). The Central East LHIN has the largest number of seniors residing within its boundaries. Seniors currently make up 14% of the Central East LHIN's population. By 2021 seniors will account for 18% of the population (IHSP Environmental Scan, 2012). Without changing how we deliver care in Ontario, in 20 years the health care system would cost $24 billion dollars more per year than we spend now (Ontario's Action Plan for Health Care, 2012). Therefore, Ontario's LHINs are planning changes to the health care system that support delivering the right care in the right place, promote value for the dollar and ensure that resources are used sustainably.

Ontario's LHINs, with a mandate to engage with the public, health care providers and other stakeholders in their local communities, are uniquely positioned to address these fiscal, demographic and technological challenges.

Provincial priorities and LHIN system imperatives

In January 2012, the province unveiled Ontario's Action Plan for Health Care to meet the challenge of managing spending growth while continuing to provide high-quality care to all Ontarians. The goal of the Action Plan is to create an "obsessively patient-centred" health care system by ensuring care is based on evidence, care is delivered in the right setting and care is coordinated so that patients move from one provider to another seamlessly.

To align the high-level goals of the Action Plan with their IHSPs, Ontario's LHINs have developed several *system imperatives*. These imperatives, highlighted on the next page, guide decisions LHINs make regarding the allocation of resources among providers and the programs and projects to be funded at the local level. Ongoing accountability will be tracked through strategic planning, accountability agreements and performance measurement.

The Action Plan identifies three areas of focus and the LHINs have identified three additional system imperatives to support Right care, Right time, Right place:

Ontario's Action Plan	LHIN-Wide System Imperatives
Keeping Ontario Healthy	Keeping Ontario Healthy
Faster Access and a Stronger Link to Family Health Care	Strengthening and Enhancing Access to Primary Care
The Right Care at the Right Time in the Right Place	Implementing Evidence Based Practices to Drive Safety Enhancing Coordination and Transitions in Care Holding the Gains

Keeping Ontario Healthy

This Action Plan priority will focus on helping people stay healthy by supporting the habits and lifestyle changes that keep people healthy. In addition to tackling childhood obesity, smoking and cancer screening, the province and LHINs will continue to work on better management of chronic conditions, such as diabetes.

LHINs across Ontario have been working with local providers on chronic disease prevention and management strategies for many years, and a strong foundation is in place to build upon. There have been many measurable accomplishments improving the way diabetes patients are treated by increasing the coordination of care and adding new resources for individuals and families.

Faster Access and a Stronger Link to Family Health Care

Family health care is the hub of the health care system for most people. Family physicians, nurse practitioners or family health care teams are ideally the first point of contact with the health care system when someone needs help. Outside of the hospital, it is also where follow-up care is provided and referrals are made to more specialized professionals. Ontario's Action Plan identifies faster access to primary care, more ways to access family health care resources, such as telemedicine points of contact and the introduction of quality measures to family health care as a key component to have a fully integrated system. The goal is to ensure appropriate care from family health care providers, to deliver right care in the right place at the right time, and help reduce hospital readmissions.

Reducing hospital readmissions will have an important effect on the sustainability of the health care system. In 2008-09, the rate for unplanned readmissions to hospital was 15% in Ontario, which the Ministry considers high compared to other jurisdictions (Enhancing the Continuum of Care, 2011). The Central East LHIN ranks 3rd in the province for 30-day readmissions, with a readmission rate of 15.08% (IHSP Environmental Scan, 2012).

Right Care, Right Time, Right Place

The *Right Care* means care informed by what the best scientific evidence and clinical guidelines have determined is the best care for individual patients. It eliminates unnecessary procedures and tests, making resources available for those who need them most.

Care *At the Right Time* means having faster access to the care you need. This could mean telemedicine or supports to help you stay at home longer, in your community close to your family and friends. This priority will also mean a renewed emphasis on preventative and proactive care for chronic conditions. Increased focus on managing chronic conditions wil reduce the number of hospitalizations a person will require, easing the strain in emergency rooms and inpatient beds across the province.

Care *In the Right Place* addresses several serious issues in the health care system. One of the most pressing is the challenge of Alternate Level of Care (or ALC) patients, who are in hospital beds, but would be best cared for in the community with support services to help maintain and improve their quality of life. In the Central East LHIN, ALC days increased from 64,822 in 2006/07 to 117,859 in 2010/11. This is the third highest number of ALC days in the province (IHSP Environmental Scan, 2012).

The *Implementing Evidence-Based Practice to Drive Safety* imperative will support the spread of evidence, tools and practices that can help providers put patient-centred and evidence-based care into practice. By reducing adverse events in all care settings (e.g. hospital, long-term care, community/home) Ontario's LHINs can build on the many patient safety initiatives currently implemented by health care providers. In partnership with Health Quality Ontario, and other key stakeholders, LHINs will work to develop coordinated plans to reduce adverse incidents that impact the quality of care and embrace best evidence-based decision making.

Another system imperative, *Holding the Gains*, will help Ontario's LHINs make sound choices about local projects by ensuring that achievements made to date are not lost as new priorities are developed and moved forward. A challenge for all organizations that periodically refresh their strategic directions, LHINs must be sure to protect the many advances they have made in improving wait-times, value for money, transparency and accountability.

In addition, over the period covered by this IHSP, the province will launch a Seniors Strategy, building on the successes of the Aging at Home program. This will put renewed focus on keeping people from being unnecessarily admitted to hospital. The expansion of community-based care and the call to empower LHINs to shift resources to where the need is greatest will be based on local needs and plans developed throughout this IHSP.

LHINs also have a mandate under this plan to further integrate the health care system, which will enable Ontario residents to navigate care easily and access the programs and services in a seamless manner. By *Enabling Coordination and Transitions of Care* the LHINs will help the health care system provide coordinated plans of care for populations that are at high-risk to assist them to get the right care when and where they need it.

Throughout this IHSP, there is close alignment with Ontario's Action Plan and the provincial appetite to transform the health care system in Ontario. The system imperatives developed by Ontario's LHINs will help guide the development of priorities that reflect the high-level goals of Ontario's Action Plan for Health.

The Central East LHIN Vision for the Local Health Care System

Building the 2013-2016 Strategy Map

A "strategy map" helps to visually capture the interconnection between vision statements, strategic directions, desired outcomes, health care priorities and enablers. This strategy map is a guide for the 2013-2016 IHSP:

- Step 1: Establish the LHIN Mission and Vision
- Step 2: Establish the LHIN Strategic Directions and System Level Outcomes
- Step 3: Set measureable strategic aims for the time period of the IHSP
- Step 4: Identify Key Enablers that will help the achievement of the strategic aims, System Level Outcomes and the LHIN Organization Vision and Mission.

1 Vision & Mission

Central East LHIN Vision
Engaged Communities.
Healthy Communities.

Central East LHIN Mission
To lead the creation of an integrated sustainable healthcare system that ensures better health, better care, better value for money.

2 Directions/ Outcomes

Strategic Directions
- Transformational Leadership
- Quality and Safety
- Service and System Integration
- Fiscal Responsibility

Population Health
- Focus on Population Health
- Equitable

Patient Experience
- Integrated
- Accessible
- Person Centred
- Effective
- Safe

Cost Control
- Efficient
- Appropriately Resourced

3 Strategic Aims

Community First

Seniors

Vascular Health

Mental Health and Addictions

Palliative and End of Life Care

4 Health System Enablers

- Improving Access to Primary Care
- Access and Wait Times
- Health System Funding Reform
- System Design and Integration
- Transitions in Care and Electronic Health Information Management
- Quality and Safety
- Community Engagement

Step #1: The Central East LHIN Vision and Mission

A vision statement is an articulation of what an organization or group of organizations aspires to achieve in the long-term. A mission statement speaks to an organization's mandate and goals that help orientate activities that will achieve the vision over time. In this 2013-2016 Integrated Health Service Plan, the Central East LHIN reconfirms its vision statement that was originally created in the fall of 2006. The ongoing reconfirmation of this vision is testimony to the enduring hopes of residents and health care providers to improve the health of our communities through an integrated health care delivery system focused

on wellness, equitable and timely access to care, that delivers high quality outcomes. Such outcomes can only be achieved through engagement and partnership with patients and their families, the full range of health care service providers, and other non-health care stakeholders that have a significant impact on the health of individuals and communities. The vision is defined as:

Engaged Communities

People are supported and proactively engaged in

- Managing their own health and wellness
- Providing direction and solutions for their health care system and their LHIN
- Coordinating the delivery of timely health care services

Healthy Communities

- Supportive and sustainable environments that address the social determinants of health and cultural competency
- Timely and equitable access to care
- The health of the population has improved

The Central East LHIN's Mission is:

To lead the creation of an integrated sustainable healthcare system that ensures better health, better care, better value for money

Step #2: Central East LHIN Strategic Directions and System Level Outcomes

To fulfill the LHIN mandate and vision, the Central East LHIN Board of Directors has also adopted four high-level strategic directions that support the achievement of a high performing health care system as defined by the Health Quality Ontario. These strategic directions and outcomes are also embedded into the Central East LHIN decision-making process.

Central East LHIN Strategic Directions:

- *Transformational Leadership:* The Central East LHIN Board will lead the transformation of the health care system into a culture of interdependence.
- *Quality and Safety:* Health care will be people-centred in safe environments of quality care.
- *Health Service and System Integration:* Create an integrated system of care that is easily accessed, sustainable and achieves good outcomes.
- *Fiscal Responsibility:* Resource investments in the Central East LHIN will be fiscally responsible and prudent.

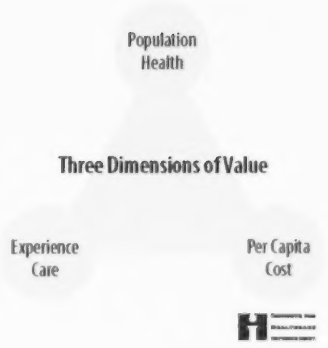
Strategic Framework: The Institute for Health Care Improvement's Triple Aim

Health care planning and decision making that intends to achieve shared goals can be a complex undertaking involving many stakeholders with competing priorities. The Central East LHIN's strategic aims essentially demand a balancing act: emphasizing one part of the health system or the health care experience may have negative and unanticipated impacts in other areas.

The Triple Aim is the simultaneous pursuit of enhancements in population health, patient experience and value for money by controlling or reducing the health care cost per capita. All this may appear easy, but experience shows that if not attended to, these aims can pull in different directions.

The "Triple Aim" strives to improve three things for a population simultaneously.
It does so by:

- Focusing on individuals and families
- Redesigning primary care services and structures
- Managing the health of a particular population(s)
- Establishing a cost-control platform
- Reinforcing system integration and execution
- Building coalitions with other sectors



The Central East LHIN is committed to the Triple Aim approach as a framework for system quality improvement that will assist us in advancing our priorities and goals.

Step #3: Setting our Aim

In a health care landscape populated by numerous performance measures, reports, programs, and data, it is difficult for consumers and health care professionals alike to understand what has changed or improved in the care they receive and the system that provides them care. While not eliminating the need for good information and multiple levels of performance measurement, the Central East LHIN has adopted the use of system level aims – or strategic aims – to help simplify what is happening in our health care system.

Strategic aims are specific and measureable in that they describe what is intended to be achieved, by how much, for whom, and by when. The use of these aims is to bring clarity in answering the question to local residents of "so what has changed?". They also provide a focal point for health care providers to align their efforts in order to achieve common objectives for the health care client.

Cascading from these strategic aims are a number of other indicators at the provider and client level that help everyone understand:

- How a particular health care provider contributes to the achievement of the system level strategic aim
- Changes in patient experience, population health and value-for-money at both the provider and regional level
- Improvements in quality as well as measures to ensure no adverse unintended consequences

Step #4: Common Enablers

Achieving these aims requires a concerted effort of the LHIN, our health service providers, other health and social service partners and, of course, our local residents and their caregivers. This IHSP identifies a set of common enablers related to health system design and improvement that consistently weave between all of our strategic aims. Those common enablers are:

- Improving Access to Primary Care
- Access and Wait Times – Including Emergency Department, Surgical and Diagnostic Services
- Health System Funding Reform
- System Design & Integration
- Transitions in Care & Electronic Health Information Management
- Quality & Safety

Overview of the Current Local Health Care System

The Central East LHIN has the second largest population in Ontario. It is home to 1,572,500 people or 11.8% of the population of Ontario. The Central East LHIN also has the fourth highest projected growth rate. It is expected that by 2021 the population will have increased by 17.0%, compared to a projected increase of 13% for Ontario overall (IHSP Environmental Scan).

The Central East LHIN is a mix of urban and rural geography and is the sixth-largest LHIN in land area in Ontario (16,673 km2). It includes densely populated urban cities, suburban towns, rural farm communities, cottage country villages and remote settlements. The Central East LHIN stretches from Victoria Park to Algonquin Park! The neighbourhoods in our planning zones boast a rich diversity of community values, ethnicity, language and socio-demographic characteristics.

MAP OF CE LHIN

- The Central East LHIN covers 16,673 square kilometres of land mass and is the sixth-largest in land area in Ontario.
- The Central East LHIN geography stretches from the culturally diverse and densely populated Scarborough planning zones to the rural and less populated areas of Haliburton Highlands, the northern sections of the City of Kawartha Lakes and Peterborough City and County.
- Population of approximately 1,572,500 – represents 11.8% of Ontario's total population.
- Central East LHIN has the second highest population within the province.
- Between 2006 and 2011 the LHIN's population increased by 5.5%, this is similar to the provincial growth rate of 5.6%.

Central East LHIN Clusters

Due to its large population and diversity the Central East LHIN has been divided into three clusters for health system planning purposes. The Scarborough Cluster is a dense urban area that includes roughly 41% of the Central East LHIN's population. This area is characterized by cultural diversity and has a relatively young population, only 5% of Scarborough residents are over the age of 65. The Durham Cluster is a largely urban area as well. This cluster has the highest level of employment and lowest levels of poverty in the Central East LHIN. The North East Cluster is a largely rural area that encompasses a great distance with just 19% of the Central East LHIN's population residing there. This cluster is characterized by its small communities and aging population. 26% of the North East Cluster's population is over the age of 65 (IHSP Environmental Scan). These clusters have unique health care needs, and many of our activities are customized for each cluster.

Key Facts about the Central East LHIN from the IHSP Environmental Scan, 2012

- Central East LHIN residents have a slightly longer life expectancy (at birth and at age 65) compared to Ontario overall (see table below).
- At 10%, the LHIN has one of the highest unemployment rates in the province.
- 16% of LHIN residents were living in low-income, the third highest among the province's 14 LHINs. This varies significantly across the LHIN. In Scarborough over 25% of the population lives in low income while, only 9.4% does in Durham.
- The Central East LHIN is 5th highest in percentage with low levels of education.
- The Central East LHIN has a relatively large immigrant population, particularly in Scarborough where 58% of the population are immigrants. This is in sharp contrast to the North East Cluster where only 9.5% are immigrants.

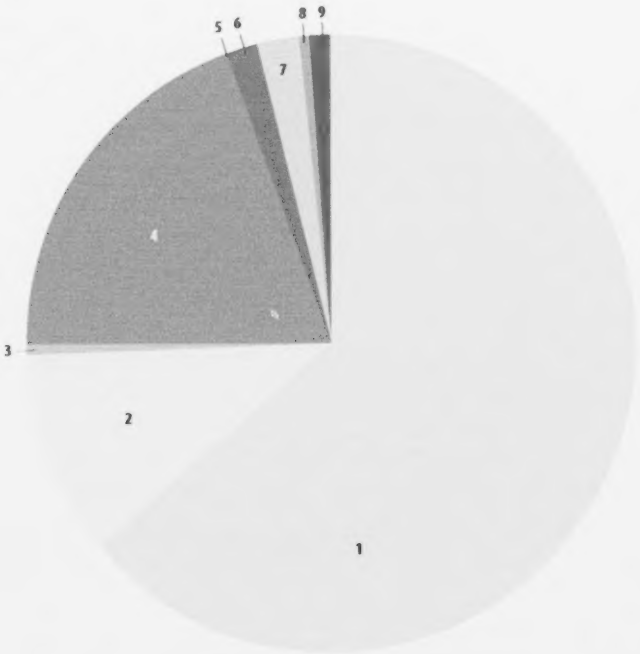
LIFE EXPECTANCY IN THE CENTRAL EAST LHIN

Central East Ontario	2007	2009
Life expectancy at birth (yrs),	82.1	81.5
Life expectancy at age 65 (yrs),	20.9	20.3

The Central East LHIN is responsible for funding more than 138 organizations including:

- 10 hospitals operating on 16 sites
- 68 Long-Term Care Homes
- 1 Community Care Access Centre
- 39 Community Support Services
- 3 Acquired Brain Injury Services
- 17 Assisted Living Services in Supportive Housing
- 7 Community Health Centres
- 27 Community Mental Health Programs
- 5 Addictions Programs

THE CENTRAL EAST LHIN ALLOCATES ROUGHLY $2,121,795,000 IN FUNDING (SEE CHART BELOW)



1. Hospitals	$1,353,821,662
2. Community Care Access Centre	$227,499,149
3. Supportive Housing	$13,899,005
4. Long Term Care Homes	$411,298,147
5. Acquired Brain Injury	$1,450,060
6. Community Support Services	$32,672,844
7. Community Mental Health	$48,243,534
8. Addictions Programs	$10,724,836
9. Community Health Centres	$22,187,148
Total	**$2,121,796,385**

Demographic information and additional information related to the strategic aims can be found in the IHSP Environmental Scan.

The 2013-16 IHSP Strategic Aims

Our Common Aim: Community First

Keeping at the forefront the health care needs of our current and future local residents, changing demographics, fiscal realities, Ontario's Action Plan for Health and the LHIN Mission and Vision, the over-arching Central East LHIN IHSP and its strategic aims can be described as Community First.

Given that 63% of the total Central East LHIN expenditures are directed to hospitals, and a further 20% is directed to the operation of long-term care homes, it may seem strange that this IHSP's focus is on Community First. Yet, the short and long-term sustainability of access to hospital-based and institutional care, along with changes in health care delivery resulting from new technology and clinical practice, are the main reasons to turn our focus to health care delivered in the community.

"Community" is generally defined as those non-hospital based services that help prevent and manage illness, thereby preventing hospitalizations resulting from poor disease management. These services typically include primary health care, home care, hospice care, mental health and addictions services, and supportive housing, to name a few. More recently, the definition of "community" is expanding to include services or programs that focus on patient and care-giver empowerment – such as the self-management for persons with chronic disease.

Every patient requiring hospital care – including emergency, surgical and specialized services – will continue to have timely access to quality services. The LHIN will continue to measure wait times and quality outcomes for hospital services. Every resident requiring a long-term care bed will be assessed based on

their need, be provided choice, and placed in a home according to availability and priority. The LHIN will continue to measure and monitor access to long-term care beds and improve the care that residents receive in their new homes.

A Community First focus will not deter from ongoing improvements to access and care within hospitals and long-term care. In fact it, we know from experience that there is a direct positive connection between hospital performance in areas such as access and readmission and available community services. Moreover, hospitals form an integral part of the community health care system whether that be through the provision of outpatient services for mental health or rehabilitation, or through the coordination of care for complex patient populations residing in the community.

The single most important reason to adopt a Community First focus is based on the needs and wishes of current and future health care clients and their caregivers.

Through our community engagement forums, we heard countless patient and caregiver stories confirming that – when given a choice – people prefer to remain healthy and independent. They want a health care system that supports them when they need it, where they need it, and treats them with respect and dignity. The place where this all begins is in a person's home and the community they live in.

Should a person require hospitalization, the health care providers should work collaboratively to ask "what do you need to return home safely?" The goal is to provide the support needed for patients to return back to their homes, connected to care that will reduce unnecessary return visits to the hospital or premature placement in long-term care.

Achieving a Community First orientation for our residents, their caregivers, health care providers, and the overall health system is no simple task. As the LHIN and its health care providers learned through the adoption of a "Home First" approach, it will require significant efforts to change culture, processes and practices, and measurement systems.

The *Home First* philosophy is premised on a basic question: "What does the patient require to return home safely?" Responding to this basic question was a massive and complex undertaking. Coordinated by the Central East CCAC and supported by all hospitals and other community health service providers in the Central East LHIN, new patient pathways and information systems were developed and implemented to support the coordination of care. Home First revolutionized the hospital discharge planning process – whereby the patient and their family are supported by an integrated hospital and community care team in establishing and putting into action a "return to home" plan supported as necessary through enhanced home care services.

This Community First IHSP, specifically through the strategic aims and enablers, is a focused and disciplined approach to create an integrated community-based health system that is able to pro-actively respond to the emerging health care trends of our communities. In the past, we have relied too heavily on theory and unsupported rhetoric that community-based care is the future of health care. With dramatic changes in-store ahead to health care finance, clinical practice, demographic shifts, and technology – these changes are too large and too important to leave to chance. *Home First* taught us that we need to be less implicit and more explicit in the coordination of patient care across health care sectors. We need a plan. That is why we have focussed the 2013-16 IHSP to be Community First.

Improving health care for seniors is a top priority of the Central East LHIN. The population of seniors is growing, and this group often has complex health care needs. As a result, there will be increased pressure on caregivers, communities and our health care system. A focus on seniors will foster improvements in the health care experience of patients and their caregivers, as well as in the overall quality and sustainability of the health care system in the Central East LHIN.

SENIORS STORY:

The large grandfather clock just inside the front entrance keeps time as Norm shares one of his stories with his latest visitor. This time it's about a speech given by a well known radio personality in Holland. She has sent along a copy of the speech to thank Norm for his contribution in liberating her village during the Second World War. He still lives in the home where he and his late wife Isabel raised their children. ***And now, at the age of 91, that's where he wants to stay.***

Who is this Priority Population?

All seniors living within the Central East LHIN are an important priority, with specific focus on those who are at danger of becoming, or are already, frail. These persons are living in their community, but on the verge of requiring placement in long-term care.

What is Frailty?

Frailty occurs when an individual has lost their resilience to "bounce back", leaving them vulnerable to a downward spiral of decline. Frail seniors have compounding issues occurring all at once and therefore require a highly coordinated system response that strives to understand and then deal with root cause(s) of the issue. This will ultimately allow health care providers to make a positive difference in the life of the individual, their family and caregiver, and enable them to live longer in their home and in their community.

Why Focus on Seniors?

The Central East LHIN will focus on seniors because there are a large number of seniors in the Central East LHIN, and because frail seniors have complex health care needs. The IHSP Environmental Scan shows that the Central East LHIN has the largest number of seniors (65+) in the province and the population is growing:

- Over 14% of Central East LHIN's population are seniors aged 65+
- Needs across the LHIN vary: 20.3% of the North East Cluster's population is over the age of 65, while 11.4% of the population in the Durham Cluster is 65+
- By 2016, seniors will account for 16% of Central East LHIN's population; by 2021 they will account for 18%

Information in the IHSP Environmental Scan also demonstrates the high health care needs that some seniors have.

- 123 of every 1000 seniors aged 75+ require Long-Term Care, the third highest rate in Ontario
- Over 40% of the 85+ population live alone in the community

A small percentage of seniors use a disproportionate share of health care resource. Of those over the age of 80, 177 out of 1000 are in the top 10% of high users (the proportion of patients with the highest combined expenses for all care types). In the 18-44 age category only 8.4 persons per 1000 would be considered to be in the top 10% of all health care users.

In the Central East LHIN, hospital Alternate Level of Care (ALC) days increased from 64,822 days in 2006/07 to 117,859 days in 2010/11 – The third highest number of ALC days in the province. ALC days accrue when a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting. The seniors' cohort comprises the vast majority of the ALC population. A high-level of ALC is problematic because patients may not be receiving the care they need and resources are not being used to their full-capacity.

Another reason that it is important to focus on improving the health care of senior is that there is a culture of ageism in Canada. There is a pervasive culture of discrimination and prejudicial attitudes towards older people, old age, and the aging process. Sometimes institutional practices and policies perpetuate stereotypes about older peoples. By promoting patient-centric care – care that focuses on the needs of individual patients – the Central East LHIN hopes to break down some of these stereotypes.

Key Accomplishments to Date

The urgency for improving health care for seniors was recognized by the Central East LHIN early on, and a number of programs have already made substantial progress.

Geriatric Assessment and Intervention Network (GAIN): GAIN clinics support seniors to remain in the community and/or regain their independence through the provision of comprehensive geriatric assessments that get to the root cause of the issues. The Central East LHIN has established 4 clinics, staffed with inter-professional teams specializing in geriatric care.

Restorative Care Programming: Restorative Care Programming consists of specialized programs and dedicated beds for geriatric activation to promote maintenance of functional status. New transitional care

and rehabilitative beds have been established in hospital and long-term care, and enhanced geriatric activation programs have been established as a standard across almost all Central East LHIN hospitals.

Assisted Living Services for High Risk Seniors: In addition to significant funding directed towards seniors' supportive housing through the Aging at Home strategy, the Central East LHIN has invested in serving an additional 350 frail seniors living in the community who are at risk of premature institutionalization and/or hospitalization.

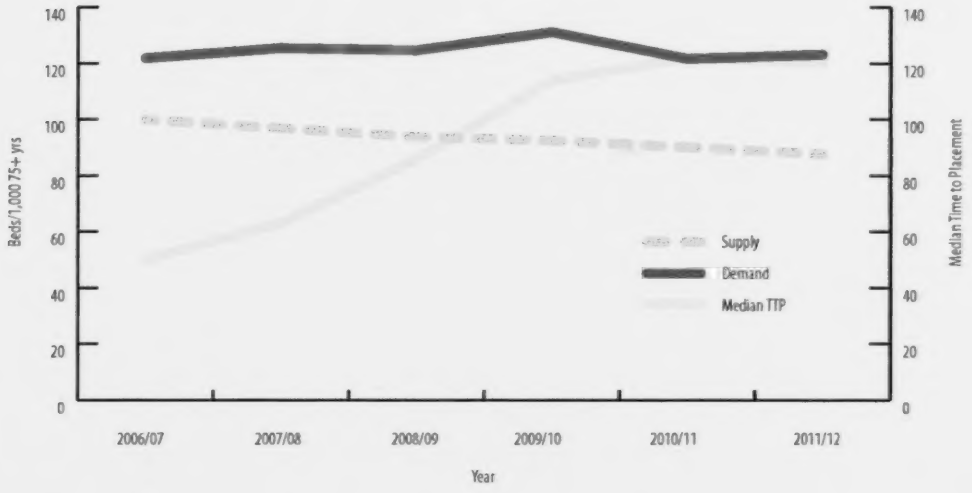
Nurse Practitioners Supporting Teams Averting Transfers (NPSTAT): NPSTAT is a region-wide initiative that consists of Nurse Practitioners supporting long-term care staff to serve residents in over 40 long-term care homes. Nurse Practitioners that are part of the NPSTAT program provide timely and safe care, in place, to help avoid preventable transfers to hospital emergency departments.

Behavioural Supports Ontario (BSO): The Central East LHIN was one of four early adopter LHINs of an innovative quality improvement initiative aimed to support long-term care residents with behavioural challenges. Initiated by an investment in additional long-term care nursing and personal support workers, teams are using less invasive tools and approaches to first understand, and then help support residents live safely in their homes without restraint.

Why This Strategic Aim for Seniors?

Based on research done by the Government of Canada we know that few seniors prefer long-term care over remaining at home. However, in the Central East LHIN demand for long-term care is relatively high. Demand for long-term care is the sum of those people currently living in long-term care, and those assessed eligible and on a wait list for long-term care. The IHSP Environmental Scan noted that while per capita demand for long-term care has declined in the other 13 LHINs since 2006/07, demand in the Central East LHIN has remained stable at 123.1/1000 residents aged 75+. This is the third highest demand for long-term care in Ontario. Although per capita demand has remained stable, the per capita supply of long-term care beds has declined due to increases in the seniors' population. As a result, wait times for long-term care placements have increased (See chart below).

CENTRAL EAST LHIN LONG-TERM CARE BEDS: SUPPLY, DEMAND AND TIME-TO-PLACEMENT*

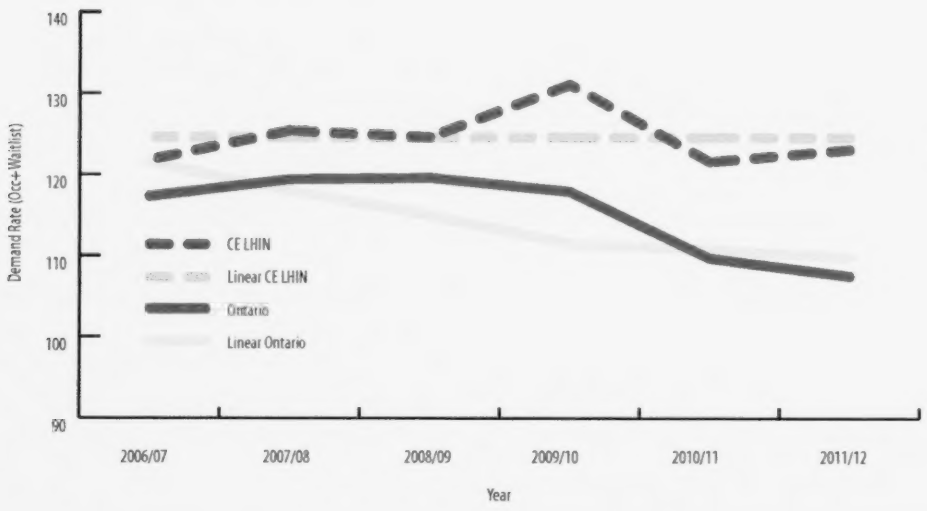


**Central East LHIN Sustainable Access Report*

A long time is needed to build additional capacity and this is a costly option. In fact, the Central East Sustainable Access Report projected a 35% increase in long-term care expenditures. However, the report also identified that the Central East LHIN is neither disadvantaged nor advantaged in its supply of long-term care beds, as the per capita rate of long-term care beds in the Central East LHIN is similar to the provincial average. The report went on to compare the Central East LHIN to other LHINs and provincial benchmarks, and concluded that other areas of investment that would benefit seniors should be prioritized before further increases to long-term care. These other priorities, such as Assisted Living and Adult Day Programs are less costly options for residential care, and more importantly they are preferred by many seniors.

To achieve this strategic aim for seniors the Central East LHIN must reduce the current Long-Term Care demand rate from 123 persons per 1000 to the current provincial rate of 107.5 persons per 1000. Unlike the rest of the province where demand for long-term care has steadily decreased since 2006, the Central East LHIN has remained stable.

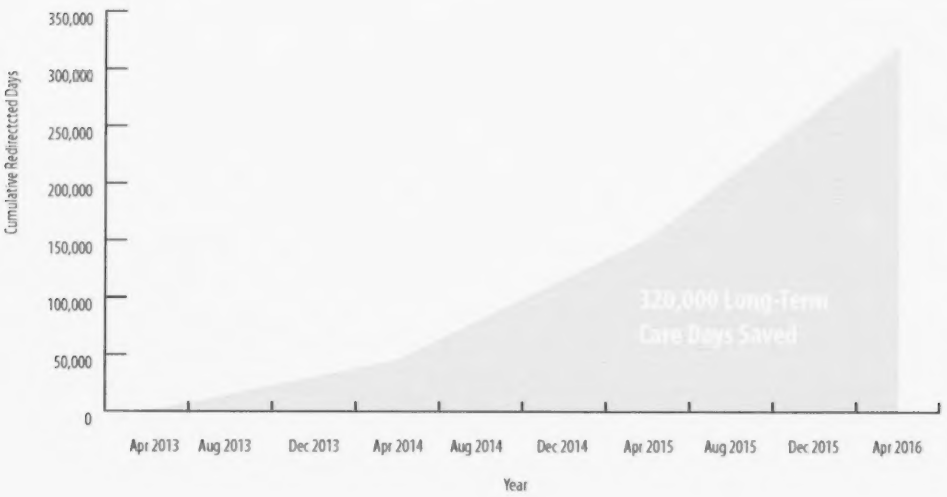
CENTRAL EAST LHIN LONG-TERM CARE DEMAND RATES



Achieving this strategic aim requires providing alternatives for home and specialized care that helps seniors stay at home and in their community rather than in a long-term care home. Not only will this aim benefit seniors who wish to stay at home or in the community, it will also benefit those who do require placement in a long-term care bed. By reducing overall demand for long-term care we will also reduce the wait time to access long-term care for those who need it the most.

Achieving the provincial demand rate for long-term care while ensuring that seniors are able to access high quality care in the community will take a concerted effort and it won't happen overnight. Our projection of 320,000 more days in the home and the community is based on a cumulative rate of improvement in which we will achieve the benchmark of 107.5 per 1000 of persons aged 75+ that require a long-term care bed

PROJECTED CUMULATIVE REDIRECTED LONG-TERM CARE DAYS



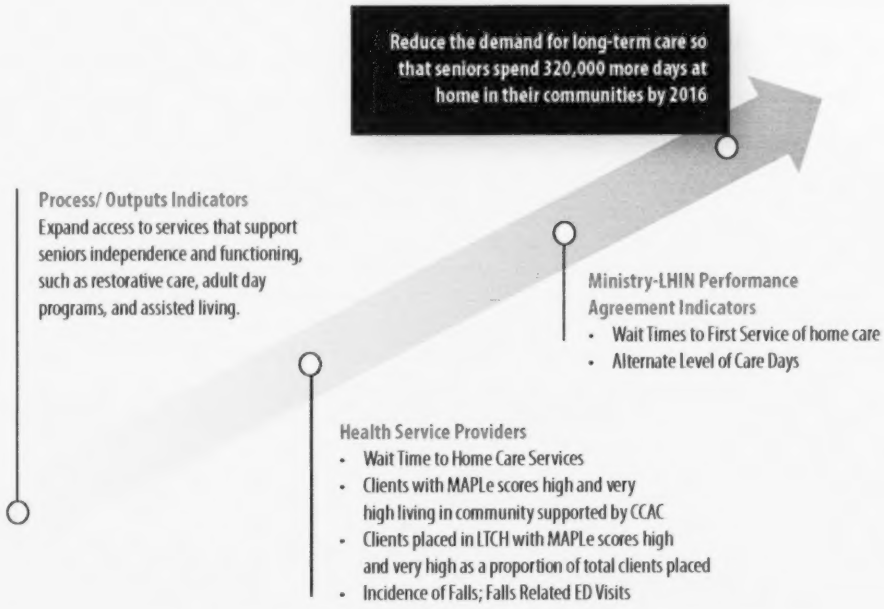
How will the Seniors Aim Be Achieved?
Partners: Individuals, Families and Caregivers, Health Service Providers - Governance, Leadership, Staff, and Volunteers, Central East Regional Specialized Geriatric Services Entity, Regional Geriatric Programs, Community Care Access Centre, Physicians - Primary Care, Specialists, and Interdisciplinary Care Teams, Community-Based Services, Public Health Units, Researchers, French Language Health Planning Entity # 4, other LHINs and the Ministry of Health and Long Term Care
Primary Care: • Improve linkages between primary health care, CCAC and specialized geriatric services to either reverse and/or manage the effects of frailty • Earlier identification of risk factors by primary care
Access: • Equity of access to specialized geriatric services across the LHIN • Implement fully the expanded role of the Central East CCAC • Strengthen shared referral process between the Central East CCAC and community support services
System Design: • Create an organized, coordinated and integrated system of specialized geriatric services • Implement Ontario's Seniors Strategy • Support caregivers • Build a stronger community sector through the Community Health Services Integration Strategy
Capacity and Funding: • Maximize current community capacity and invest in new/additional supports to enable frail seniors to remain at home in their communities (e.g. assisted living, caregiver supports, adult day programs)
Transitions & Electronic Health Information Management: • Implement Resource Matching and Referral (RM&R), an electronic solution for matching the needs of the individual with the appropriate service • Implement new CCAC Transitional Care Nurses to support safe transitions from hospital to home

Quality & Safety:

- Continue spreading Behavioural Supports Ontario to all long-term care homes and then into the community
- Develop and implement a shared Falls Prevention Strategy
- Senior friendly hospitals

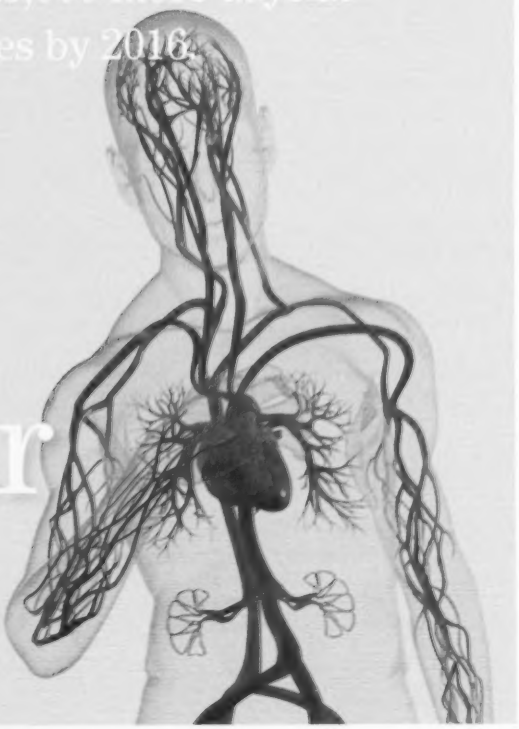
Measuring Progress:

Like the LHIN Health System Performance Indicator Framework, a hierarchy of performance measures will be used to measure progress. The indicators were designed to support organizational and system performance measurement, guided by the strategic areas of focus for the LHIN, and the performance of health care providers that, together, will result in the achievement of this strategic aim


Reduce the demand for long-term care so that seniors spend 320,000 more days at home in their communities by 2016
Process/ Outputs Indicators
Expand access to services that support seniors independence and functioning, such as restorative care, adult day programs, and assisted living.
Ministry-LHIN Performance Agreement Indicators
• Wait Times to First Service of home care
• Alternate Level of Care Days
Health Service Providers
• Wait Time to Home Care Services
• Clients with MAPLe scores high and very high living in community supported by CCAC
• Clients placed in LTCH with MAPLe scores high and very high as a proportion of total clients placed
• Incidence of Falls; Falls Related ED Visits

Continue to improve the vascular health of residents so they spend 25,000 more days at home in their communities by 2016

Vascular Health



Vascular health is a concern across Canada. The prevalence of vascular disease is high, and many individuals are at risk for developing vascular conditions. Improving vascular health, and effectively and efficiently managing vascular disease, will reduce the impact of vascular disease on individuals and the health care system.

VASCULAR STORY:

After two heart attacks Phil is taking responsibility for managing his own vascular health, being an advocate, watching his diet, exercising to the best of his ability. He visits a clinic to sort out how medications for a number of underlying conditions are impacting his ability to control his weight. He would like to see more services out in the community where people could receive co-ordinated care from an integrated team who could provide ongoing assessment, clinical care, nutrition and life style information. Perhaps that way he could avoid the next attack, the one that has him worried.

Who is this Priority Population?

Vascular disease is more than just a heart attack. Vascular diseases are a broad group of health conditions that affect almost all parts of the body – from head to toe. Vascular disease includes cardiovascular (heart disease), cerebrovascular (brain disease) including vascular dementia and stroke, and peripheral vascular

disease which presents in other areas of the body such as kidneys, arms and legs. Vascular disease impacts our individual health and our health care system. Vascular disease is characterized in our bodies by a thickening or narrowing of the arteries that move blood through our bodies. It is this thickening or build-up inside arteries (artherosclerosis) that is commonly referred to as 'hardening of the arteries'. Vascular disease can damage eyes and cause blindness, restrict blood flow to the brain resulting in memory-loss (dementia) or stroke, cause heart attacks or heart failure, raise blood pressure, impair kidney function, and cause swelling or inflammation in arms and legs (peripheral vascular disease) which can lead to tissue loss (gangrene, wounds) and possible limb amputation. Some people are at particularly high risk of developing vascular disease including:

- Seniors
- People with diabetes, reduced kidney function, heart disease, or who have experienced a stroke
- Visible Minorities

Ensuring that these groups can access care is a top priority; and, the Central East LHIN Vascular Health Strategy is focused on secondary prevention of disease and modification of risk factors for those with high needs.

Why Focus on Vascular Health?

Despite reductions in the number of people who die each year from vascular diseases it remains the number one threat to the health of Canadians. Vascular disease is a major cause of illness, disability, hospitalization and death in the Central East LHIN and across Canada. Nine out of every ten Canadians over age 20 have at least one risk factor for vascular disease and one in three have more than one risk factor (Public Health Agency of Canada: 2009). Type 2 diabetes, although not a vascular disease, is one of the largest contributing modifiable risk factors to vascular disease. Heart disease and stroke are the number one cause of death and disability among those with type 2 diabetes; and, adults with diabetes are two to four times more likely to have heart disease or a stroke than adults without diabetes (American Heart Association).

A number of factors contained in the IHSP Environmental Scan suggest that a focus on vascular health is warranted in the Central East LHIN. Obesity puts people at risk for vascular disease and, 53% of the Central East LHIN's residents are overweight or obese. The incidence of obesity has been increasing over time. The prevalence of some health conditions that are related to vascular disease is higher in the Central East LHIN than across the province (see table below). In particular, the Central East LHIN has the highest rate of diabetes across the province.

PREVALENCE OF CHRONIC CONDITIONS

Condition	Central East LHIN	Provincial Average
Diabetes	7.9%	6.9%
Heart disease	5.5%	4.9%
High blood pressure	17.6%	17.4%

In addition, 17% of Central East LHIN residents have multiple chronic conditions, which is significantly higher than the provincial rate (15.2%). Comorbidities make vascular disease management more complex and can result in additional health issues. Based on data collected to measure hospital performance we know that in 2011 over 15% of people with vascular disease were readmitted to hospital within 30 days of their discharge in the Central East LHIN. This suggests that the immediate health care needs of some of those with vascular disease are not being appropriately met.

A focus on vascular health aligns with an important provincial strategy. The Ontario Integrated Vascular Health Strategy (OIVHS) was initiated to develop an Integrated Vascular Health Strategy for Ontario which aligns with the Canadian Heart Health Strategy, the Canadian Stroke Strategy and the Ontario Chronic Disease Prevention and Management Framework. The overall goal of the OIVHS is to reduce the prevalence and consequences of vascular and related diseases. Successful implementation of this strategy will contribute to a more economically sustainable health care system in Ontario. This strategy will focus on four targeted areas for change:

1. Population health and promoting healthy public policy
2. Understand and support the individual and family through their vascular health journey
3. Improve the quality and access to vascular services
4. Develop system enablers that will ensure efficient use of resources

The Central East LHIN supports this strategy and has aligned its aim and Vascular Health strategy with the OIVHS.

Key Accomplishments to Date

The importance of vascular health was noted in the Central East LHINs 2010-13 IHSP and the related Vascular Health Strategy.

In 2010 the Central East LHIN set a strategic aim to reduce the impact of vascular disease by 10% (10,000 inpatient days). It's projected that *44,063 inpatient days will be saved for vascular disease by March 2013.* This has been accomplished through a number of initiatives. We have increased awareness of and access to:

- Client and caregiver chronic disease self-management training
- Service provider training in self-management support
- Acute stroke care
- Cardiovascular rehabilitation
- Inter-professional diabetic care
- A comprehensive chronic disease management approach for people with all stages of chronic kidney disease

Why This Strategic Aim for Vascular Health?

Continued improvement in the vascular health of residents and increasing the number of days people spend in their homes by 25,000 days requires inter-sectoral action between hospital, primary and specialty care, the Central East CCAC and community agencies in partnership with patients and their families. This strategic aim was chosen because it requires various stakeholders to work in an integrated way to deliver services and supports to patients and their families. Expanding or initiating collaborations, partnerships, transfer or mergers of services are necessary to achieve this aim. The goal of spending 25,000 more days at home in the community equates to 25,000 less days spent in hospital. As such, efforts to reduce avoidable hospitalizations will be a core focus namely:

- Reducing readmissions to hospital, which could have been avoided if the care in hospital or the care after discharge was optimized;
- Preventing initial hospitalizations which could have been prevented with comprehensive primary care focused on chronic disease management and prevention for patients with ambulatory-care sensitive conditions;
- Reducing hospital days due to preventable adverse events in hospital.

Since 2010, our focus on the Central East LHIN Vascular Health Strategy has demonstrated that the benefits of our accomplishments compound over time. We will continue to build upon the

gains of the past three years. As projects ramp-up and positive benefits become apparent, we will save more and more inpatient days. By 2015-16 we expect to have saved an additional 25, 000 hospital in-patient days related to vascular causes. (see chart below).

HOW WILL THE VASCULAR HEALTH AIM BE ACHIEVED?

How will the Vascular Health Aim be Achieved?
Partners: Patients, Families and Caregivers, Central East LHIN Vascular Health Coalition, Provincial Vascular Health Blueprint Implementation Teams, Hospitals – Governors, Administrators and Clinicians, Primary Care providers, Central East LHIN Primary Care Leads, Central East CCAC, Ontario Renal Network, Central East LHIN Renal Steering Committee, Central East LHIN Diabetes Regional Coordinating Centre and Steering Committee, Ontario Stroke Networks in Central East LHIN, other LHINs and the Ministry of Health and Long Term Care, French Language Health Planning Entity # 4
Primary Care: • Diabetes and vascular health grand rounds • Self-management support training for clinicians • Collaborative shared care for people with chronic kidney disease • Ontario Integrated Vascular Health Strategy – Blueprint
Access • Centralized intake for diabetes education and management including complex diabetic care • Equitable access to cardiovascular secondary prevention and management • Primary PCI and Code STEMI capacity in the Northeast Cluster • Enhanced access to stroke acute and rehabilitation services
System Design • Hospital and community smoking cessation partnerships • Implement stroke care best practices • Regional coordination of vascular services, cardiac rehabilitation, stroke care and rehabilitation

Capacity and Funding

- Implement Quality Based funding procedures for:
  - Chronic Kidney Disease (CKD)
  - Stroke
  - Congestive Heart Failure (CHF)
  - Coronary Artery Disease
- Telemedicine OTN vascular clinical & education opportunities

Transitions & Electronic Health Information Management

- Planning for discharge
- Improved communication between health professionals in different settings as well as between clinicians and patients
- Medication reconciliation and management when the patient returns home
- Patient and caregiver education
- Timely primary care follow-up

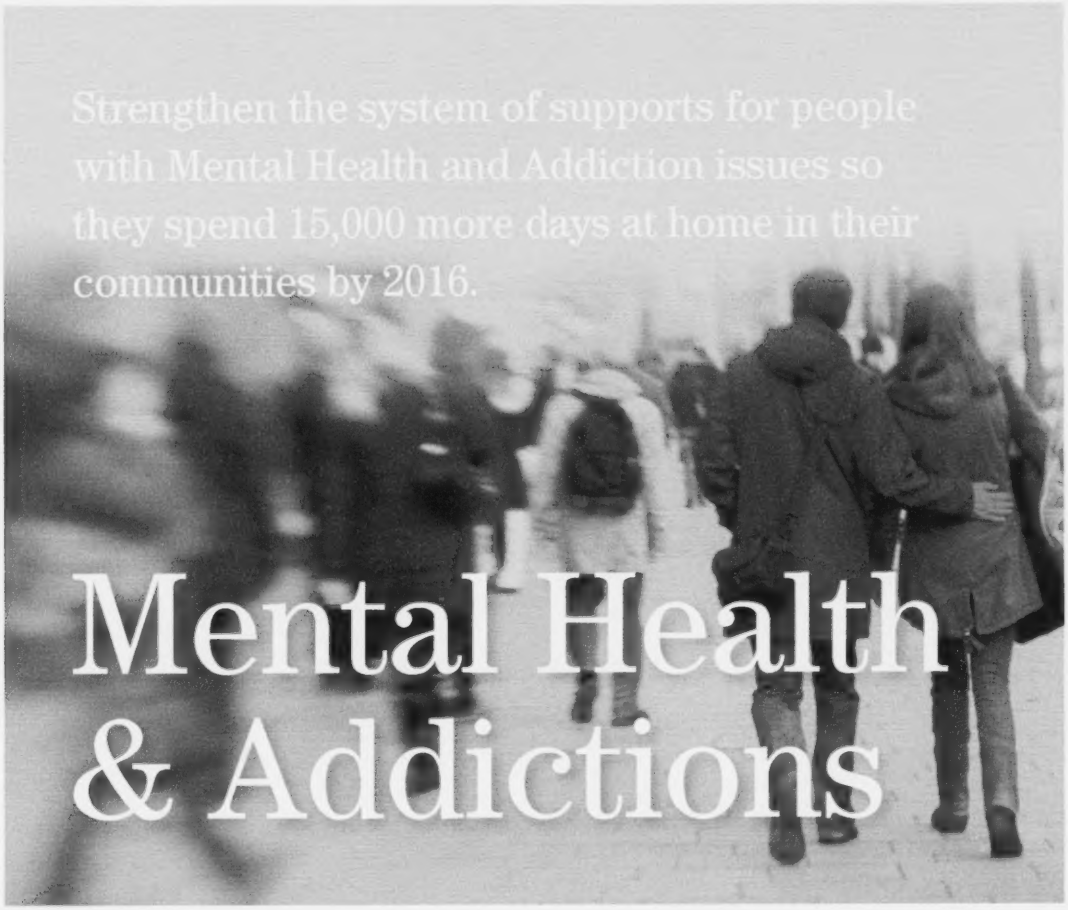
Quality & Safety

- Patient self-management training
- Implement evidenced based care pathways for stroke, CKD and other quality based procedures
- Coordinated equitable access to vascular surgical services

Measuring Progress:

Like the LHIN Health System Performance Indicator Framework, a hierarchy of performance measures will be used to measure progress. The indicators were designed to support organizational and system performance measurement, guided by the strategic areas of focus for the LHIN, and the performance of health care providers that, together, will result in the achievement of this strategic aim.

Continue to improve the vascular health of residents so they spend 25,000 more days at home in their communities by 2016
Process/ Outputs Indicators
Implement Central East LHIN high priority vascular health initiatives
Ministry-LHIN Performance Agreement Indicators
Reduce hospital readmissions for vascular disease
Health Service Providers
• Reduce 30 Day Readmission Rate for CHF, Cardiac, Stroke and Diabetes
• % of Stroke Patients Admitted to Inpatient Rehab



Strengthen the system of supports for people with Mental Health and Addiction issues so they spend 15,000 more days at home in their communities by 2016.

Mental Health & Addictions

Mental health and/or substance abuse issues can be very disruptive to individual and family lives. When interventions are less disruptive and focused on connecting individuals with the right care, outcomes are improved. Ensuring that those with mental health and addictions issues are provided with proper supports will positively impact individuals and families as well as the health system at large.

MENTAL HEALTH AND ADDICTIONS STORY:

Virginia's son Ben was diagnosed as suffering from schizophrenia over twenty years ago. "The ACT Team is great. They come just about every day to make sure he's taking his medication. But he needs his own house, his own place to live. He's had to move back in with me because there isn't any housing for people with his type of illness here in our local community. It's not good. Its not good for both of us. **He needs the supports so that he can continue to live in a home in his own community and so that he can be accepted."**

Who is this Priority Population?

Health care for people who have a self-identified, or diagnosed, serious mental health and/or addiction issue is a priority in the Central East LHIN. Those who are at greatest risk or face the greatest challenges in

obtaining appropriate care will be a particular focus over the next three years. Groups that will be central to this strategic aim include:

- Persons with concurrent disorders or physical disabilities
- Seniors or older adults with complex medical and social needs
- Persons with addictions, including expectant mothers
- First Nations, Metis, Inuit and Non-Status peoples
- Adolescents, school-age and transitional aged youth who are migrating from youth to adult system

Why Focus on Mental Health & Addictions?

Mental health and addictions issues represent serious challenges to individuals, families, the health care system and society at large. Alcohol and illicit drug use in the Central East LHIN has an estimated economic cost, (direct and indirect) of $915.15 million annually, (Central East LHIN Addictions Scan, 2009). Excellent health care can have a profoundly positive effect on those who are affected by mental health and addiction issues. However, these people experience significant barriers in accessing the primary health care system and other broader health supports, such as housing and food. This raises their risk of other health problems such as diabetes and cardiac disease.

If appropriate care is not provided, people with mental health & addictions issues may become frequent users of the urgent care system. In the 2011 IHSP Environmental Scan the Central East LHIN was ranked 10th among the 14 LHINs in repeat unplanned emergency visits within 30 days for Mental Health conditions, with a return rate of 17.6%. The Central East LHIN was ranked 5th in repeat unplanned emergency visits within 30 days for substance abuse conditions in 2011, with a return rate of 22.0%. An early return visit suggests that the care that was needed in order to remain at home or in the community was not provided. Addressing the care needs of those with mental health and addiction issues will decrease pressure on emergency departments in the Central East LHIN, but more importantly it will also improve outcomes for those individuals.

Key Accomplishments to Date

The successes of the following initiatives will provide a strong foundation for improving mental health and addictions care.

The Durham "ED Avoidance Coalition" (2009-10): The Durham "ED Avoidance Coalition" Initiative created integrated hospital and community teams designed to support service users to avoid unnecessary visits to the Emergency Department. It established a new, enhanced integrated model of care that focused on service recipients by providing services, such as access to community crisis beds.

Hospital to Home Initiative: The Hospital to Home Initiative builds on the accomplishments of the "ED Avoidance Coalition" by establishing ongoing integrated hospital and community teams in the Durham and North East Clusters.

Consumer Survivor Initiative Integration in the Durham and North East Clusters: Integration of peer-led services in both the Durham and North East Clusters has directed more resources to front line services and established a strong peer support network across the Central East LHIN. Peer and vocational support services are now accessible to more people across both the Durham and North East Clusters.

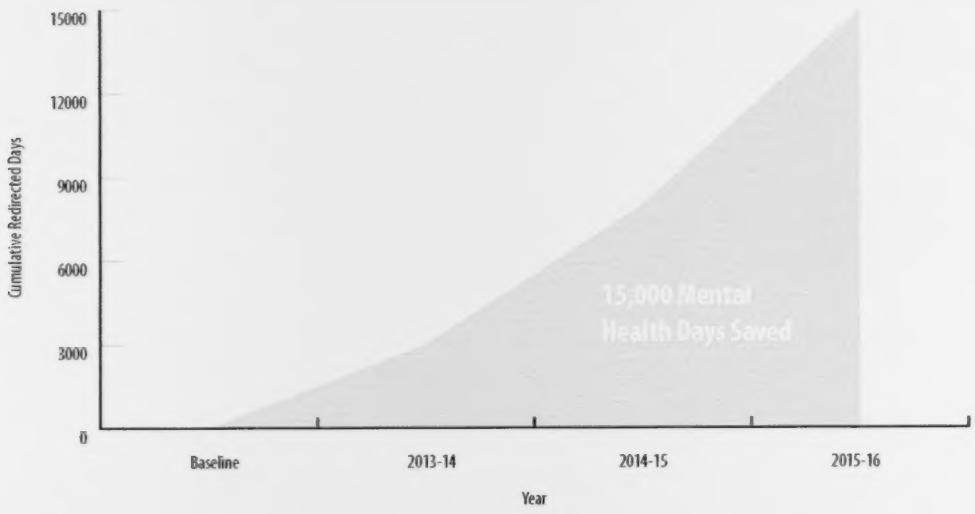
Why This Strategic Aim for Mental Health and Addictions?

Research done by the System Enhancement Evaluation Initiative demonstrated that people with concurrent disorders are the most frequent visitors to Central East LHIN emergency departments and have the most unscheduled return visits. Early revisits indicate that the client's needs were not met, or they were not connected with supportive community services during the initial hospital visit. A visit to the emergency

department can even exacerbate a crisis situation for someone who has a mental health and/or substance abuse issue. The Central East LHIN Addictions Scan found that some people had visited the emergency department over 80 times before being transitioned to the level of care that they required. An integrated system of care that focuses on community resources is more likely to provide the care that is needed by those with mental health and addictions issues.

It is recognized that the challenges faced by those with mental health and addictions are complex – it will take time to make meaningful change. We expect benefits to accumulate over the next three years giving those with mental health and addiction issues the opportunity to spend 15,000 more days at home in their communities (see chart below). This will be achieved by enhancing the coordination of care between health care providers and addressing service gaps in the continuum of care – thereby reducing the total number of days mental health and additions clients require hospital or emergency department care.

HOW WILL THE MENTAL HEALTH & ADDICTIONS AIM BE ACHIEVED?



How will the Mental Health & Addictions Aim be Achieved?
Partners: Clients, Families and Caregivers, Central East Mental Health and Addictions Network, Primary Care Network, Central East LHIN Aboriginal Health Planning Circles, Central East LHIN Hospital and Community Health Service Providers, Central East Acquired Brain Injury Network, Central East LHIN Consumer Survivor Initiative Network, Multi-sectoral partners including public health, municipalities, housing authorities, school boards and other Ministries, other LHINs and the Ministry of Health and Long-Term Care, French Language Health Planning Entity # 4
Primary Care: • Support integration and capacity building between primary care and mental health & substance abuse service providers • Develop access points between providers and systems that will ensure effective transitions from service to service for the client • Explore and implement self-management options for mental health and substance abuse patients

Access

- Improve system access through ACTT Quality Improvement Initiative and LHIN-wide planning for child and adolescent mental health
- Inform providers and the public of information sources such as CONNEX Ontario
- Establish a "menu" of cluster-based services to ensure local access to basic supports
- Implement recommendations of the Central East LHIN Addictions Scan, 2009 by ensuring access to withdrawal management services in the Scarborough Cluster

System Design:

- Design an integrated system that places the service recipient at the centre of care and ensures most effective use of resources
- Design a holistic system that is connected with other health and multi-sectoral partners
- Continue to explore integration opportunities to streamline service delivery and business operations

Capacity & Funding:

- Together hospitals and communities will function as an integrated system which will improve capacity and make the best use of funding resources
- Quality Improvement principles will advise future investment

Transitions & Electronic Health Information Management:

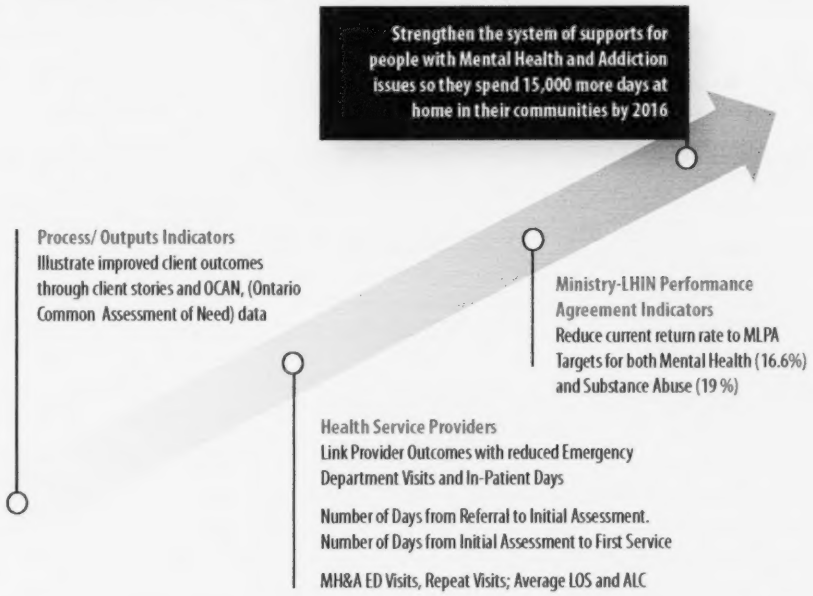
- Support the implementation and sustainability of the Ontario Common Assessment of Need (OCAN) and the Integrated Assessment Record (IAR)
- Support the implementation of a Common Assessment Tool (CAT)
- Support common data collection and interpretation practices across the Central East LHIN

Quality & Safety:

- Monitored through accountability agreements with providers
- Supported by cluster- based Hospital to Home Teams working within Quality Improvement principles
- Ongoing Quality Improvement initiatives such as ACTT Quality Improvement Initiative and Schedule 1 Bed Registry

Measuring Progress:

Like the LHIN Health System Performance Indicator Framework, a hierarchy of performance measures will be used to measure progress. The indicators were designed to support organizational and system performance measurement, guided by the strategic areas of focus for the LHIN, encouraging health care providers to work together in support of improved outcomes and experiences.


Strengthen the system of supports for people with Mental Health and Addiction issues so they spend 15,000 more days at home in their communities by 2016
Process/ Outputs Indicators
Illustrate improved client outcomes through client stories and OCAN, (Ontario Common Assessment of Need) data
Ministry-LHIN Performance Agreement Indicators
Reduce current return rate to MLPA Targets for both Mental Health (16.6%) and Substance Abuse (19 %)
Health Service Providers
Link Provider Outcomes with reduced Emergency Department Visits and In-Patient Days
Number of Days from Referral to Initial Assessment.
Number of Days from Initial Assessment to First Service
MH&A ED Visits, Repeat Visits; Average LOS and ALC

Increase the number of palliative patients who die at home by choice and spend 12,000 more days in their communities by 2016.

Palliative Care

All Central East LHIN residents have the right to die with dignity, to have access to physical, psychological, bereavement, and spiritual care, and to be granted the respect consistent with other phases of life. Ensuring timely access to quality palliative and end of life care is not only an ethical imperative but a vital component of our health care system.

PALLIATIVE AND END-OF-LIFE CARE STORY:

It started when her daughter fainted at work and bumped her head and went to the hospital. They said it was just a concussion and told her to eat more but Anne, now in her late seventies, was worried when, two days later, her adult daughter Mary could only drink liquids. The bad news came after a visit to the local clinic. Inoperable pancreatic cancer that quickly metastasized in her liver and spread throughout her body. ***"We did what she wanted and what I knew was right and brought her home to spend the remaining time surrounded by family and friends."***

What is palliative and end of life care?

Palliative and end of life care is an approach to caring for people who are living with a life-threatening illness. It focuses on achieving comfort and ensuring respect for the person nearing death and maximizing quality of life for the patient, family and loved ones. Palliative and end of life care is holistic in nature and aims to:

- address physical, psychological, social, spiritual and practical issues and their associated expectations, needs, hopes and fears
- prepare for and manage self-determined life closure and the dying process
- cope with loss and grief during the illness and bereavement

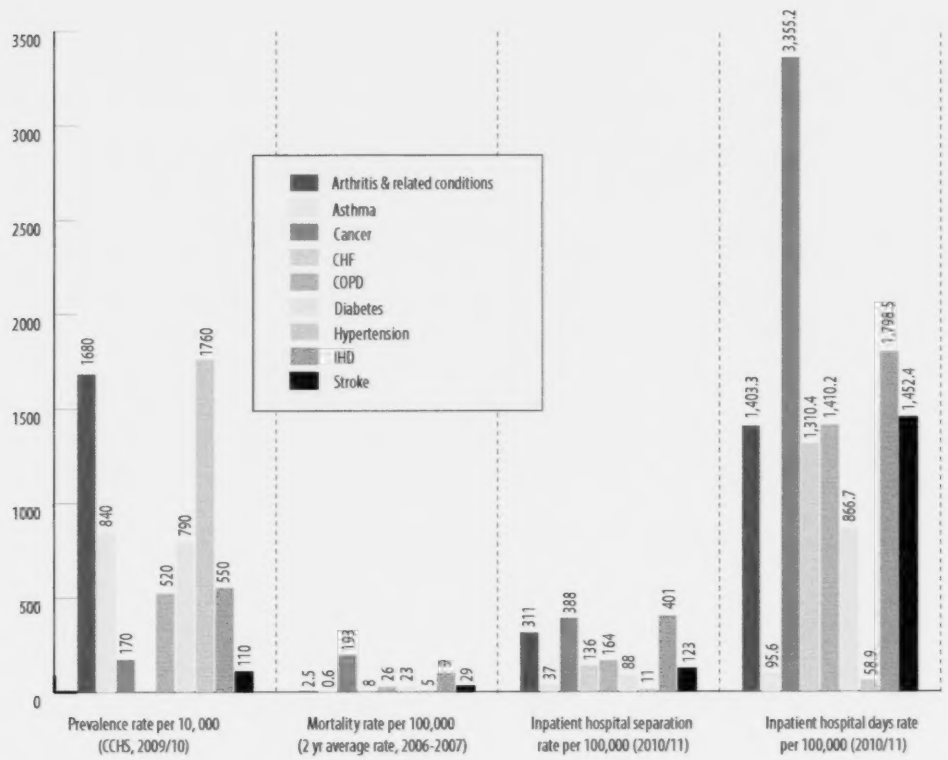
Services include community based palliative care services; hospital based palliative programs; clinics and beds; Community Outreach Nurse Practitioners; specialty teams; palliative education and consulting services; community services and community hospice services including day programs, friendly visiting, grief and bereavement, respite and caregiver supports.

Why Focus on Palliative Care?

There is significant need for palliative and end of life care services and supports. As the population continues to age, chronic illness and advanced co-morbid conditions are becoming increasingly common. In particular:

- Over 14% of the LHIN's population are seniors aged 65 years and over. By 2016, seniors will account for 16% of the LHIN's population; by 2021 they will account for 18%.
- Chronic conditions account for 6 out of 10 deaths, 1 out of 5 acute hospital discharges, and 1 out of 4 acute hospital days for LHIN residents.
- Heart disease (including ischemic heart disease (IHD), congestive heart failure (CHF) and stroke) accounts for an additional 10% of all hospital days and 9% of all acute care discharges.

CENTRAL EAST LHIN BURDEN OF CHRONIC CONDITIONS



Mounting disease rates and an aging population have translated into a heightened utilization of acute care facilities. In 2011-2012, 4,716 residents were admitted into hospital for palliative care, accounting for 59,195 hospital days (These numbers do not include patients who were admitted into hospital at the end-of-life but were not admitted into a designated palliative care program or coded as "palliative").

The Central East LHIN aims to better support and inform patients of their choice to receive palliative and end-of-life care at home or in their communities. Advance Care Planning, for example, involves proactive discussions with family, friends and health care providers. It is a planning process in which individuals reflect on their values and wishes to let others know their future health needs and preferences in the event they become incapable of decision making as they near the end-of-life. Currently, there is need for enhanced palliative assessments and heightened cultural awareness surrounding Advanced Care Planning.

Key Accomplishments to Date

The Central East LHIN has begun putting programs in place that will enhance cultural awareness, expertise and service availability to support patients and families in need of palliative and end of life care.

Palliative Pain and Symptom Management Consultation: The Palliative Pain and Symptom Management Consultation service supports service providers in home care agencies, long-term care homes, community support services, and primary care settings by providing access to Palliative Pain and Symptom Management Consultants. These positions provide consultation, education, mentorship and linkages to palliative care resources across the continuum of care.

Community Palliative Nurse Practitioner Program: The Community Palliative Nurse Practitioner (CPNP) Program strengthened community supports by enhancing the availability of NPs and their capacity to facilitate quality care to palliative clients in the home.

Standardization of Palliative Education Services: A variety of streamlined programs and activities have been developed. Resources have been aligned, resulting in improved equitability and accountability of educational services.

Strengthened Community Hospice Services: Investments were made in innovative hospital-community partnerships to improve access to end-of-life care in all settings. This has strengthened the sustainability and value-for-money in Community Hospice services across the Central East LHIN.

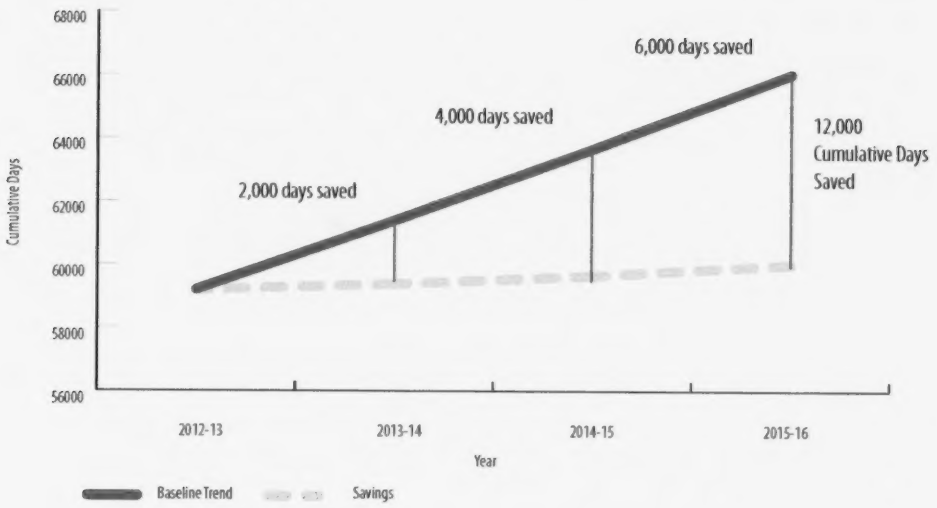
Why This Strategic Aim for Palliative Care?

Achievement of this aim requires the coordinated actions of hospitals, primary and specialty care, the CCAC and community agencies in partnership with patients and their families. Actions will focus on reducing the number of days palliative patients spend in hospitals waiting for an alternate level of care, increasing hospital palliative discharges to home with community supports, reducing the average hospital length of stay for patients by supporting them at home or in the community as long as possible, reducing hospital deaths and decreasing emergency department visits for palliative patients. These measures will help palliative patients to receive access to high quality and compassionate care where they live.

This strategic aim will also help support Ontario's proposed new model for hospice palliative care as identified in the provincial document, *Advancing High Quality, High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action*. In particular, it will encourage adults and children with life threatening illnesses and/or advanced or chronic conditions to receive care that is proactive, holistic, person and family-focused and centered on quality of life and delivery of care by inter-professional teams in all care settings.

In achieving this aim, the Central East LHIN anticipates incremental measures of change over the next three years. By 2016, the Central East LHIN will increase the number of palliative patients who die at home by choice and spend 12,000 more days in their communities by 2016.

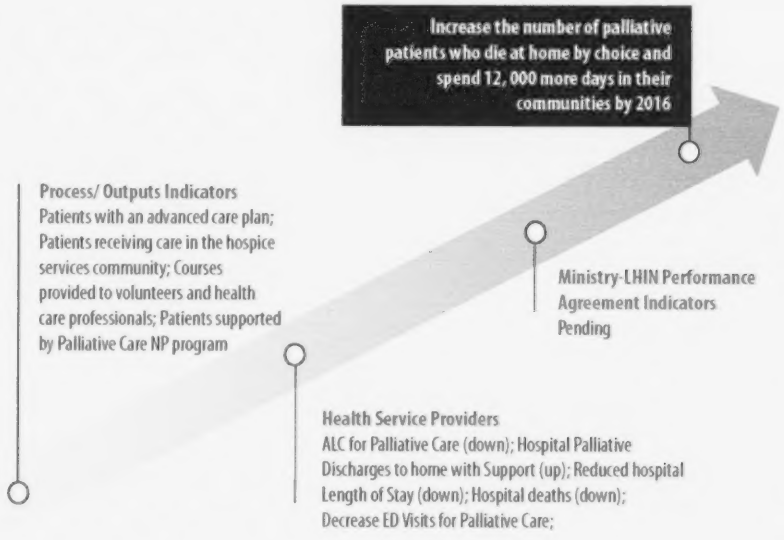
HOW WILL THE PALLIATIVE & END OF LIFE CARE AIM BE ACHIEVED?



How will the Palliative & End of Life Care Aim be Achieved?
Partners: Patients, Families and Caregivers, Central East Hospice Palliative Care Network , Provincial End of Life Care Networks, Community Hospice providers and their volunteers, Community Care Access Centre, Ontario Medical Association, Primary Care providers, Interdisciplinary Care Teams, Community Palliative Nurse Practitioners, Long Term Care Homes, other LHINs and the Ministry of Health and Long-Term Care, French Language Health Planning Entity # 4
Primary Care: • Education and leadership opportunities for primary care • Expand and promote Advanced Care Planning in primary care settings
Access • Establish outreach processes through the CCAC and primary care to identify individuals with advanced chronic disease and connect them with inter-professional care
System Design: • Integrate community and hospital services to support a LHIN-wide Palliative Care Program coordinated at the local level • Pursue opportunities for residential hospice • Strengthen community hospice through the Community Health Services Integration Strategy
Capacity & Funding: • Increase the number of community palliative care nurse practitioners to support individuals, families and professional caregivers
Transitions & Electronic Health Information Management: • Utilize e-Health solutions to improve patient discharge and help clients locate alternatives to care • Support transitional care options outside of the hospital
Quality & Safety: • Expand and promote standardization of hospice, palliative and end of life care programs in long term care homes and hospitals.

Measuring Progress:

Like the LHIN Health System Performance Indicator Framework, a hierarchy of performance measures will be used to measure progress. The indicators were designed to support organizational and system performance measurement, guided by the strategic areas of focus for the LHIN, encouraging health care providers to work together in support of improved outcomes and experiences.


Increase the number of palliative patients who die at home by choice and spend 12, 000 more days in their communities by 2016
Process/ Outputs Indicators
Patients with an advanced care plan; Patients receiving care in the hospice services community; Courses provided to volunteers and health care professionals; Patients supported by Palliative Care NP program
Ministry-LHIN Performance Agreement Indicators
Pending
Health Service Providers
ALC for Palliative Care (down); Hospital Palliative Discharges to home with Support (up); Reduced hospital Length of Stay (down); Hospital deaths (down); Decrease ED Visits for Palliative Care;

Health System Design, Integration and Improvement

In order to achieve the 2013-16 strategic aims, fulfill the LHIN mission, and meet our accountabilities to the Ministry of Health and Long-Term Care, the LHIN will continue with current and new initiatives that will improve patient experience and strengthen the performance of the overall health care system.

In this section, Health System Design, Integration and Improvement, we identify the common themes or enablers that will weave through all of our strategies and actions, and will ultimately lead to achievement of our objectives. The common enablers are:

- Improving Access to Primary Care
- Access and Wait Times
- Health System Funding Reform
- System Design and Integration
- Transitions in Care and Electronic Health Information Management
- Quality and Safety

Improving Access to Primary Care

Primary health care is the first point of contact a person has with the health system – the point where people receive care for most of their everyday health needs. Primary care providers are integral in facilitating smooth transitions in care, and they are an essential element of any individual's health care. It is encouraging that 93% of Central East residents report that they have a regular family doctor. However, only 70.3% of LHIN residents are satisfied with the availability of care in general (IHSP Environmental Scan, 2012). Data collected from public surveys suggests that access to family doctors may still be problematic for some Central East LHIN residents. Some individuals who have the highest need for excellent primary care are least able to access it. The lowest rate of enrollment in patient-enrolled models of primary care is in the 90+ age cohort.

Guided by the Action Plan's proposal to bring the organization of primary care under the mandate of the LHINs, the Central East LHIN continues to work closely with primary care providers. Our initial focus is building and strengthening our partnership with primary care, and their partnerships with other parts of the health care system. With the support of primary care leadership, efforts are underway to improve

the care coordination between primary care and other health services, as well as improving timely access to primary care as an alternative to a hospital visit. Primary Care initiatives have been identified in each of our system priorities. The following are additional areas of focused improvement.

What	Enhancing Access to Primary Care
How	• Raise profile of primary care through networking • Support the adoption of Advance Access (same day appointments) to primary care • Work with system partners to identify and support people at high risk of hospitalization or re-admission • Leverage Information Technology (e.g., Electronic Medical Records) capacity to support informed, proactive care of patients within primary care and their transitions in care
Partners	• Central East LHIN Primary Care Leads • Central East LHIN Primary Health Care Advisory Group • Primary health care and other health care providers
Measuring Success	• Number of people who are connected to care through Health Care Connects • Ambulatory Care Sensitive Hospital Admissions and Re-Admissions • Hospital patient discharge information provided to primary care within 48hrs

Access and Wait Times – Emergency Department

The time patients spend waiting for care in the emergency department (ED) will continue to be a key area of improvement for the Central East LHIN and its health service providers. A common outcome of the 2013-2016 IHSP's Community First theme and strategic aims is to improve emergency department wait times – especially for those patients requiring hospital admission – by:

- Decreasing avoidable emergency department visits and hospitalizations, including re-admissions; and
- Reduce hospitalization length of stay and ALC Days

Through the Ministry of Health and Long-Term Care's Emergency Department Pay for Results Program, the LHIN will continue to incent hospitals to improve or hold the gains made in reducing emergency department wait times.

Accomplishments to Date

Significant progress has been made by the Central East LHIN in reducing wait times and meeting provincial targets (see tables below). As of July 2012, the Central East LHIN met all wait time targets as set in the Ministry-Central East LHIN Performance Agreement.

Performance Indicator	FY 2009/10	FY 2010/11	FY 2011/12
90th Percentile ER Length of Stay for Admitted Patients	48.00	51.62	44.53
90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	8.00	7.40	6.83
90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	5.10	4.50	4.33
Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution	18.41%	20.22%	17.35%

(Ministry-LHIN Performance Agreement Indicators Dashboard)

What	Access and Wait Times – Emergency Department
How	• Central East Pay For Results Program • Focused additional human resource and quality improvement initiatives • Continued deployment of Home First to minimize ALC days • System level initiatives that will prevent avoidable ED visits, hospital admissions and re-admissions
Partners	• Central East LHIN Emergency Department Lead, and Hospital Leadership • Central East LHIN Critical Care Lead, and Hospital Leadership • Central East LHIN Primary Care Lead • Hospital and Community Providers, specifically those collaborating to provide crisis support services to patients in the community and/or faster access to community services upon hospital discharge
Measuring Success	• ED visits per 1000 population • ED Wait Times for admitted patients, and high and low-acuity non-admitted patients • Alternate Level of Care Days • Repeat unplanned ED Visits or hospital readmission within 30 Days

Health System Funding Reform

The recently initiated Health System Funding Reform will evolve Ontario's health care system away from the current global funding system towards what is known as *Patient-Based Funding (PBF)*. Under Patient Based Funding, health care organizations will be compensated based on how many patients they look after, the services they deliver, the evidence-based quality of those services, and the specific needs of the broader population they serve. Starting with hospitals and Community Care Access Centres in 2012, Patient Based Funding will be expanding in scope and will reach maturity in 2014. It is also anticipated that PBF will spread to other health care sectors.

Patient Based Funding is intended to serve as an equitable and sustainable funding model that will also standardize care, minimize practice variation and encourage investments in quality improvement and patient safety.

Going forward, hospitals' funding will be comprised of three different streams. Hospitals will still receive some *global funding* but the balance of hospital funding will be determined through two components: Health Based Allocation Model (HBAM) and Quality Based Proceedures (QBP). *Health Based Allocation Model (HBAM)* estimates expected health care expenses based on (i) population profiles and (ii) clinical complexity and type of care. Allocations are then adjusted according to differences between actual and expected health care expenses. *Quality Based Procedures (QBP)* provides reimbursement to health care providers based on the types and quantity of patients they treat. HBAM will make-up roughly 40% of hospitals' funding, with the remaining 60% being divided evenly between QPBs and Global Funding (see chart to the right).

PLANNED HOSPITAL PATIENT BASED FUNDING (BY 2014)

Over the term of the 2013-2016 IHSP the Central East LHIN will engage in system capacity planning to ensure that services are not negatively impacted by the transition to the new funding models. The Central East LHIN will continue to examine how to best meet the health care needs of our growing and changing population. Taking an overall system perspective, the Central East LHIN is able to look across the continuum of care to help determine:

- Gaps in service that are creating health inequities
- Alternative service delivery models that can deliver patient-centred care more effectively at a lower cost
- Reduce variation in standards of care, patient outcomes, and costs
- Capacity planning will continue to be done in all health sectors, but it is expected that focused planning efforts will be required to support the implementation of *Health System Funding Reform* in the hospital and CCAC sector. Such an example is the development of an Integrated Orthopaedic Capacity Plan for the Central East LHIN (see System Design & Integration below).

What	Health System Funding Reform
How	• Supporting Ministry and Health System Funding Reform, in particular the three year roll-out of Quality Based Procedures through: • Lead collaborative and evidence-based decision making to optimize access, equity, system capacity and value-for-money • Support spread of standardization of care pathways that will reduce variation in practice, and improve patient outcomes in quality and safety • Undertake service capacity planning and implement service regional delivery models that are responsive to community need and the new funding model • Identify and reduce conservable hospital days.
Partners	• Health Service Provider Clinicians, Administrators and Governors, starting with Hospitals and CCAC / Ministry of Health and Long-Term Care / Other LHINs
Measuring Success	• Wait Time and Quality indicators for selected Quality Based Procedures. • Patient Outcomes related to quality and safety • Balanced Budgets

System Design and Integration

A major focus of all LHINs is health system design and integration activities to improve the quality of client care, performance of the local health system and system sustainability. These activities are an important undertaking to help shape the direction of the health care system in light of changing client preferences, community demographics, funding models and on-going advances in medicine. Integration and system design activities are best done locally as they require extensive local community engagement in order to mesh best-available information and standardized clinical practices with local circumstances.

At present, the most ambitious integration planning activity during the 2013-16 IHSP will be the *Community Health Services Integration Strategy*. Involving over 29 community health service providers, including Community Health Centres (CHCs), Community Support Services agencies (CSS) and some hospitals, the aim of this facilitated effort is to: *Design and implement a cluster-based service delivery model for CSS and CHC agencies by 2015 through integration of front-line services, back office functions, leadership and/or governance to:*

- improve client access to high-quality services,
- create readiness for future health system transformation and,
- make the best use of the public's investment.

(*Presentation to the Central East LHIN Board of Directors*, February 2012)

Planning and implementation of new models for community health services is expected to be complete across the Central East LHIN by March 2015.

Other current or expected system design and integration activities in the 2013-16 timeline include:

1. Ongoing implementation of the Central East LHIN Hospital Clinical Services Plan recommendations, specifically related to:

- Advanced Neonatal and Pediatric Program for the Central East LHIN
- Development of a coordinated, regional model of Adolescent In-Patient Mental Health and Addictions

2. Capacity planning and service delivery models in support of Health System Funding Reform, including but not limited to:

- The Integrated Orthopaedic Capacity Plan which aims to develop an improved model for elective and non-elective orthopaedic surgical procedures identified under the Quality Based Funding Model (both confirmed and anticipated). This process will also look at post-acute rehabilitation capacity and service delivery models. Specifically, the Integrated Orthopaedic Capacity Plan will consider:

  - LHIN and sub-LHIN based access ("sizing and siting")
  - Current and future (5 year) service capacity (supply) and demand (utilization);
  - Emerging changes in clinical practice, care pathways, and the use of technology;
  - Quality and other performance standards (e.g., effective, efficient, appropriate, safe, person-centred);
  - Service program standardization across providers, where appropriate;
  - Health human resources, including physician workforce.

- The Integrated Orthopaedic Capacity Plan is expected to be compete in the Spring of 2013, with implementation thereafter.

What	System Design and Integration Activities
How	• Community Health Services Integration Strategy (2012-2015) • Integrated Orthopaedic Capacity Plan • Final implementation of Clinical Services Plan recommendations, specifically in maternal-newborn care and adolescent mental health and addictions • Other facilitated, funded, voluntary or required integrations as outlined in the Local Health System Integration Act • Capacity in change management through the dissemination of integration skills training, tools and mediation among health service providers • Community engagement and public relations
Partners	• Health Service Providers – Clinicians, Staff and Governors / Public / Clients
Measuring Success	• Achievement of the Community Health Services Strategic Aim • Implementation of local and regional service delivery model(s) that realizes gains in access, quality and costs • Re-investment in client services resulting from efficiencies

Transitions in Care and Electronic Health Information Management

Electronic Health Information Management is a crucial enabler of health system improvements. Electronic Health Information Management can boost value for money by increasing the efficiency of operations, and by providing the data and analytics tools to improve decision-making. This data can also improve the quality of care by driving evidence-based practice and enabling a focus on the measurement of health outcomes. Electronic Health Information Management can also better the quality of care by addressing the movement of patients between organizations and increasing information shared across providers. It can enhance patient experience by empowering patients through portals, home technology enablement and the dissemination of tools.

Electronic Health Information Management is a provincial priority. The Central East LHIN will spend time on important provincial initiatives, such as eHealth Ontario's integrated Electronic Health Record strategy, that are underway or will be rolled out over the next three years. The Central East LHIN will provide various types of support depending on the type of initiative. Some initiatives will require leadership from the Central East LHIN, others will only necessitate awareness on the part of the Central East LHIN. Locally, Central East LHIN Electronic Health Information Management initiatives are focused on seven key areas to drive health system advances:

1. *Integration and Transitions:* Technology enablers will be critical to support patient transitions between organizations and the required information flow. For example, Resource Matching and Referral (RM&R) is considered a critical technology enabler to manage patient flow.

2. *Acute Care:* Although Electronic Health Information Management is important, hospitals are often challenged by implementations due to fiscal and operational constraints. The LHIN can continue to play a role in Electronic Health Information Management implementations by facilitating discussions to allow for joint planning and identification of common needs, providing data to support decision-making, and supporting the standardization of data structures.

3. *Community-Based Care:* The community-based care sector will benefit from Electronic Health Information Management, however smaller community organizations often lack the capacity to implement and maintain technology solutions. There is a role for the LHIN to understand and review shared services that larger health service providers could host on behalf of community care. Technology is also being used in various ways within the community sector – CCAC Case Managers use laptops for assessments, and pilots using ipads and teleconsults are underway. The Ontario Common Assessment of Need (OCAN) is a standardized consumer-led, decision-making tool that assists with mental health recovery. OCAN captures the consumer's voice by identifying individual needs, matching these needs to existing services and highlighting service gaps. The interRAI Community Health Assessment (CHA) is the instrument that has been chosen by the Community Support Sector. The interRAI CHA is a standard tool for community support services that allows for data collection on a wide selection of community support services to support evidence-based care while informing future program development and resource allocation. The Integrated Assessment Record (IAR) facilitates transitions in care. It is an application that allows authorized users to view a consenting client's assessment information to effectively plan and deliver services to that client.

4. *Primary Care:* The Central East LHIN IMIT Advisory Group supports the need to engage the primary care domain within the Electronic Health Information Management strategic planning process. Better integration between electronic medical record solutions and service catalogues could improve referrals directly to community care.

5. *Patient/Consumer:* With the shift to community care, it is recognized that patients will need to take more accountability for their care; technology enablers for patients to assist in their education and self-management will start bending the demand curve.

6. *Decision Support:* The movement towards funding based on performance and metrics means that high-quality data is required. Standardized minimum data sets and data mapping tools for specific reporting needs and priorities are needed.

What	Electronic Health Information Management Activities
How	• Implementation of Resource Matching and Referral (RM&R) • Support end-user adoption of Electronic Medical Records and eHealth Ontario's integrated Electronic Health Record strategy of implementing an integrated Electronic Health Record (iEHR) by 2015. • Monitor implementation of Ontario Laboratory Information Systems, Diagnostic Imaging repositories, and Community Care Information Management initiatives, and Hospital Report Manager. • Continue to drive delivery of Timely Discharge Information System, a tool that is used to exchange information within the Primary Care system. • Facilitate discussions between health service providers in a variety of sectors to allow for joint planning • Support the development of data definition standards and mapping tools
Partners	• eHealth Ontario • Central Ontario LHINs Electronic Health Information Management Cluster • Health Service Providers, including Primary Health Care providers
Measuring Success	• Completion of the strategic planning process • Implementation of Resource Matching and Referral (RM&R) for select case mix-groups • Reduced hospital Alternate Level of Care Days • Hospital admissions & readmissions, and hospital conservable days • Wait times from initiation of service to receipt of service • Number of clients with shared assessments between health service providers

Quality and Safety

In support of the *Excellent Care for All Act*, LHINs play an important role in improving the quality and safety of care patients receive. While significant progress has been made, adverse events - such as falls, medication errors, infections, preventable wounds and pressure ulcers, avoidable medical interventions and restraints, and pre-mature mortality – are still unfortunate experiences for our patients. Although prevention of diseases and promotion of healthy behaviours are the best way to improve patient outcomes, we need to ensure that:

- Patients can access services that help them manage, improve or cure their disease, and/or
- When patients do require health care, they are not harmed by the care they receive, or by the environment in which they receive their care.

As a result, the Central East LHIN will continue to monitor key quality and safety indicators across the health care sector. We will work with health care providers, provincial stakeholders such as Health Quality Ontario and the Change Foundation to support quality improvement in patient outcomes and patient-driven care. The Central East LHIN will also review health service provider Quality Improvement Plans in order to identify strengths and areas for improvement such as hospital-based mortality, maternal-newborn care, medication reconciliation, wound management, and diabetes care.

What	Quality and Safety
How	• Include, monitor and improve quality and safety indicators in Health Service Provider's Service Accountability Agreements • Review health service provider Quality Improvement Plans (QIPs) and identify areas of strength and improvement • Promote standardization of practice through Quality Improvement Initiatives and funding reform • Collaboration with Health Quality Ontario and the Change Foundation • Regularly report on the Central East LHIN Balanced Scorecard (Quality & Safety) to the LHIN Board and public
Partners	• Patients / Health Service Providers, including governors, administrators and clinicians / Health Quality Ontario
Measuring Success	• Patient satisfaction improvements, selected hospital and CCAC performance indicators related to infections, nursing sensitive conditions, readmissions, preventable clinical interventions, falls, pressure ulcer and wound management